

Who Gets Second Opinions?

Once a technique for controlling inappropriate care, second medical opinions have become a controversial practice under managed care.

BY TODD H. WAGNER AND LISA SMITH WAGNER

ABSTRACT: Six states require health plans to provide or authorize second medical opinions (SMOs). The intent of such legislation is to preserve consumer choice, to improve the flow of information, and to improve health outcomes in this era of managed care. However, it is unclear who benefits from these laws. This paper reviews the changing role of second opinions and, using

a nationally representative data set from the Commonwealth Fund, examines who gets them. Of persons who had visited a doctor in the previous year, 19 percent received a second opinion, for an estimated cost of \$3.2 billion in 1994. Findings suggest that cultural norms and sociocultural factors may partially determine who may benefit from SMO legislation.

ALTHOUGH GETTING second medical opinions (SMOs) is a widely recognized practice, little is known about who gets second opinions, why people get them, or the frequency with which they are obtained. Seemingly a benign topic, SMOs are the latest political battleground in a culture where consumers are demanding choice and health plans are trying to control costs.

In this paper we examine the evolution of second opinions as a medical procedure, tracing it back to an era when obtaining one was not always the patient's choice. Under fee-for-service reimbursement, second opinions were used by providers as a cost-containment strategy before managed care made its mark. As reimbursement has changed, so has the role of second opinions. In prepaid or capitated systems SMOs do not generate revenue, so providers try to maintain control over when and how they are used. Limiting their use, however, clashes with consumers' desire for more information and choice. Six states (Florida, Indiana, Louisiana, Missouri, New Hampshire, and New York) have passed laws

to preserve access to and coverage for second opinions. California is considering legislation for the third consecutive year. It is not clear who will benefit from such legislation, because we know very little about who uses SMOs.

Using a nationally representative, cross-sectional data set from the Commonwealth Fund, we assess the prevalence of second opinions and the factors associated with getting them. The discussion section brings these two themes together, along with directions for future research.

EVOLUTION OF SECOND OPINIONS

In the early 1970s insurance companies started using SMOs as a utilization review technique (called second surgical opinion programs, or SSOPs) to reduce costs associated with overuse and inappropriate surgery.¹ With this fundamental change, getting a second opinion was no longer a choice. Rather, patients facing elective or high-cost surgery were required to get one to verify that the procedure was clinically appropriate.²

Todd Wagner is a health economist with the Veterans Affairs (VA) Health System in Menlo Park, California. Lisa Wagner is an assistant professor in the psychology department at the University of San Francisco.

SSOPs' effectiveness at decreasing inappropriate surgeries and costs was questionable.³ Yet, under prepayment, SSOPs are no longer needed to monitor utilization. Used by 50–75 percent of provider organizations in 1992, SSOPs likely have been discontinued or replaced with quality-enhancement programs.⁴ Although no data exist on the use of SSOPs since 1992, the number of articles on SSOPs listed in Medline and ABI/Inform has declined, which suggests that they are falling into disfavor.

CONSUMER INFORMATION

The dispute over SMOs is part of the larger debate over the tensions between cost containment and consumer choice and protection. Patients are increasingly viewed as potential victims in a system where prepayment establishes financial incentives that could lead to undertreatment and where physicians face pressures to conserve resources and have limited time to keep up with the medical literature. The best means for controlling costs while protecting patients from being improperly treated are not obvious. Some see a need for an institutional-level code of ethics, because power that once rested with physicians has shifted to managed care organizations.⁵ More recently, the federal government has let states grapple with these issues.⁶ Consequently, states have passed and are continuing to consider a potpourri of “managed care reform” legislation, making it difficult for health plans, providers, and consumers to keep up with the changes.

Each state has constituents who want to impose more command-and-control regulations and others who want to allow the market to regulate itself. As a compromise between these two extremes, many policymakers are supporting informational regulations, such as the Patients' Bill of Rights, which the Senate passed in the summer of 1999. Information regulations involve making sure that consumers have choices and that they have the necessary information to facilitate decision making. Legislating information standards is common in the retail sales

of cigarettes, alcohol, and food products, where warnings or nutritional facts are posted on the labels.⁷ Present-day interest in informational regulations, however, goes beyond warning labels to issues such as access to second opinions.

Determining what health information should be provided to consumers is a daunting if not impossible task. In some situations, such as the Medigap insurance market, setting information standards has been successful.⁸ However, providing information to patients who are making various treatment decisions is more complicated. SMO legislation shifts attention away from the content of the information and focuses instead on access to information.

Patients and consumer groups have lobbied state legislators, claiming that second opinions are crucial for obtaining unbiased health information and that access to and coverage for them is being unjustly restricted.⁹ In response, health plans have stated that SMOs are provided when appropriate. Although we know very little about who uses SMOs and even less about how they affect outcomes, policymakers are increasingly willing to pass SMO legislation.

STATE LEGISLATION

Florida, Indiana, Louisiana, Missouri, New Hampshire, and New York all have laws protecting patients' access to SMOs and establishing when insurers or health plans can be held financially responsible (Exhibit 1). Explicit financial liability has been addressed by only three of those states (Florida, Missouri, and New York). In general, however, the health plan or insurer is accountable for most charges associated with the SMO. In Florida, the state with the most-specific legislation, patients may go to a physician who is unaffiliated with their health plan, and the plan is responsible for all usual, reasonable, and customary charges. Health plans in Florida are allowed to include coinsurance rates and copayments for second opinions in the enrollee's contract, but the enrollee's responsibility is capped at 40 percent. While these laws help

EXHIBIT 1**Existing And Pending Legislation On Second Medical Opinions In Seven States****Existing legislation**

State	Law covers	Law specifics
Florida	HMO enrollees	SMO is allowed if enrollee disputes the appropriateness or necessity of surgery or is subject to a serious injury or illness, including not responding to current treatment plan
		SMO provider is chosen by plan, but all of the details must be stated in enrollee's contract
		Provider is responsible for all charges that are usual, reasonable, and customary Patient's responsibilities must be stated in contract and are capped at 40 percent
	Workers' compensation	Patient may obtain one SMO Health professional providing the SMO must be in the same specialty, within provider's network, and SMO must be provided during the episode of care
Indiana	HMO enrollees	SMO is provided upon enrollee's request Health plan chooses who provides the SMO Financial arrangements are not specified
Louisiana	Workers' compensation	SMO is provided upon enrollee's request Who will provide the SMO is not specified Financial arrangements are not specified
Missouri	Health services corporations	SMO is provided upon enrollee's request SMO is guaranteed only for major surgery, other treatment requiring general anesthesia, or serious illness involving loss of bodily part or function
		Health services corporation can restrict access to participating plan providers if they have the appropriate medical expertise Patient is responsible only for costs that would have been incurred for a similar initial medical opinion
New Hampshire	Workers' compensation	SMO is provided upon enrollee's request Who will provide the SMO is not specified Financial arrangements are not specified
New York	All medical providers	Restricted to persons with a diagnosis of cancer Patient is responsible for costs that would have been incurred for a similar referral
	Workers' compensation	Applies to managed care organization enrollees only Patient may seek SMO from approved panel of health care providers Second opinion is binding unless third opinion is sought Employer/carrier is responsible for all charges of such opinions

Pending legislation

California	All health care service plans and disability insurers	SMO is provided upon enrollee's request (with defined limits) or at the request of the health professional who is treating the enrollee Health services corporation can restrict access to participating plan providers if they have the appropriate medical expertise Patient is responsible for copayments that would have been incurred for similar referrals
-------------------	--	---

SOURCES: Florida Insurance Code, sec. 641.51; Florida Labor Code, sec. 440.134; Indiana Insurance Code, sec. 27.13.37; Louisiana Labor and Workers' Compensation Code, sec. 23.1221; Missouri S.B. 754 (signed into law in 1998); New York Insurance Code, sec. 4303, New York Workers' Compensation Code, sec. 126 (expires and repealed 31 December 2000); New Hampshire Workers' Compensation Code, sec. 281-a:23; and California A.B. 12, "Health Care Coverage: Second Opinions" (1999).

NOTES: HMO is health maintenance organization. SMO is second medical opinion.

to clarify coverage for the first SMO, few states have included contingencies for conflicting second opinions or for covering third or fourth opinions.

SMO laws may be part of workers' compensation regulations, state insurance codes, or both. New Hampshire and Louisiana passed laws that changed workers' compensation, while Indiana and Missouri passed laws that only affected health maintenance organizations (HMOs) and health services corporations, respectively. New York passed legislation for workers' compensation and amended the health insurance code to protect cancer patients' access to SMOs.

The laws also establish when a patient has a right to a second opinion. Florida's code, for instance, states that the subscriber has a right to one "in any instance in which the subscriber disputes the organization's or the physician's opinion of the reasonableness or necessity of surgical procedures or is subject to a serious injury or illness."¹⁰ Missouri's law mandates access to SMOs only for "major surgery or other treatment necessitating general anesthesia or other serious illness involving loss of bodily part or function."¹¹

The laws also establish which health professionals may furnish SMOs. The usual point of contention is whether patients in prepaid health plans must see a network-affiliated physician or may go to an unaffiliated physician. States vary on this issue. Indiana's law states that the SMO shall come from "an appropriate participating provider."¹² New York's code, on the other hand, states that the patient can select a consulting physician from within the provider's network or choose a provider in the same geographical service area of the organization.

Interestingly, five of the six states have no working definition of *second medical opinion*. Florida is the exception, defining an SMO as a "consultation by a physician other than the member's primary care physician, whose specialty is appropriate to the need, and whose services are obtained when the member disputes the appropriateness or necessity of a surgical procedure, is subject to a serious in-

jury or illness, including failure to respond to the current treatment plan."¹³

■ **THE BATTLE IN CALIFORNIA.** California experienced substantial opposition to its SMO legislation (A.B. 341) in 1997 and 1998. Forty-one organizations representing patient and consumer interests backed the legislation, and nine insurance companies and health plans opposed it. In their dissenting opinion the opposition stated that many health care organizations, including HMOs, already permit and encourage the use of SMOs when necessary and appropriate. They opposed A.B. 341 because it did not place sufficient restrictions on the number of SMOs that an enrollee could request, thus potentially leading to abuse of the system. After numerous revisions, A.B. 341 stated that an "SMO shall be considered medically necessary or appropriate if any one of the following occurs: (1) if the enrollee questions the reasonableness or necessity of recommended surgical procedures; (2) if the enrollee questions a diagnosis or plan of care for a serious illness; (3) if the clinical indications are not clear or are complex and confusing; (4) if the treatment plan in progress is not improving the medical condition of the enrollee within an appropriate period of time; (5) if the enrollee has serious concerns about the diagnosis or plan of care."¹⁴

After approval by the California Assembly and Senate in 1998, A.B. 341 was vetoed by Gov. Pete Wilson (R). The law was stymied by the opposition's desire to limit SMOs to a patient's medical group. This requirement was not added to the bill because the proponents maintained that it would not yield an unbiased or trustworthy second opinion and thus would thwart the spirit of the legislation. A.B. 341 has been resurrected in the 1999 session as A.B. 12, with the hopes that the state's new governor, Gray Davis (D), will sign it into law if it is approved by the legislature.

SURVEY DATA

To begin looking at the use of SMOs in the United States, we obtained data from the Commonwealth Fund Survey of Minority

Health conducted by Louis Harris and Associates in the spring of 1994. The telephone survey used random-digit dialing and oversampled minorities in the forty-eight contiguous states and Washington, D.C. Interviews were conducted with 3,789 adults ages eighteen and older, yielding a response rate of 60 percent. Details of the sampling methodology and other findings have been reported elsewhere.¹⁵

The survey queried respondents about their use of health services in the previous twelve months. Respondents who stated that they had visited a health professional or medical facility in the past year were then asked if they had obtained an SMO. Responses were categorized as yes, no, or not sure. Although no definition of *second opinion* was provided to the respondents, only sixteen persons (less than 1 percent) stated that they were not sure; these persons were omitted from further analysis.

Bivariate analysis was conducted to compare the receipt of an SMO across variables representing sociocultural factors, perceptions of care, and health need. Multivariate analysis was conducted using logistic regression.¹⁶ Sampling weights reflecting sex, race, age, educational attainment, and health insurance status were constructed by Louis Harris. These weights correct for the overrepresentation of minorities and underrepresentation of white non-Hispanics in the survey, allowing for analyses that are nationally representative. Statistical analyses were done with Stata, in which the standard errors were adjusted for the probabilistic sampling.¹⁷ Given the exploratory nature of this study, a 90 percent confidence level was used in the multivariate analysis.

RESULTS

Approximately one of every five persons who visited a health professional in the past year also sought an SMO (Exhibit 2). Health need and location of care were associated with getting a second opinion.¹⁸ Use of SMOs varied by sociocultural factors, but household income was not related to their use. Use of

SMOs varied considerably by health insurance coverage: Approximately 15 percent of uninsured persons got an SMO, while 25.6 percent of persons covered by public insurance outside an HMO received one.

Rates of getting an SMO were highest among white non-Hispanics (19.5 percent) and lowest among Hispanics (14.1 percent). Respondents who felt that they would have received better care if of a different race were more likely to get an SMO. In addition, persons who reported being treated badly were much more likely to get a second opinion.

The multivariate results confirmed the association between the use of SMOs and insurance type, sociocultural factors, health need, and perceptions of the health care system.¹⁹ Among HMO enrollees with private insurance, the odds of getting an SMO were 2.7 times greater than they were for HMO enrollees with public insurance (Medicaid or Medicare managed care). Among persons with public health insurance, the odds of getting an SMO were 2.3 times greater for those who were not in an HMO than for those who were enrolled in an HMO.

■ **EDUCATION.** Persons with less than a high school education were approximately three times less likely than persons with a college degree to have received an SMO. After controlling for the other variables, age and overall self-reported health status were no longer associated with the use of second opinions. Also, income and having a regular doctor were not important in the bivariate or multivariate analyses.

■ **PERCEPTIONS OF THE HEALTH CARE SYSTEM.** For persons who thought they were treated badly, the odds of getting an SMO were 1.6 times greater than they were for those who did not feel this way. Approximately 6 percent ($n = 225$) thought that they would have received better care if they were of a different race; those who felt this way were more likely to get an SMO than those who did not feel this way. Also, persons who had a health problem, disability, or handicap that kept them from participating fully in work, school, housework, or other activities

EXHIBIT 2

Use Of Second Medical Opinions (SMOs) By Persons Who Visited A Health Professional In The Past Year, 1994

	Received an SMO
Overall	18.8%
Sex**	
Male	16.1
Female	21.1
Age**	
18-44	16.7
45-64	20.9
65 and older	22.8
Ethnicity/race	
White non-Hispanic	19.5
Black/African American	16.9
Asian/Pacific Islander	17.9
Other	17.8
Hispanic origin**	
Yes	14.1
No	19.2
Marital status	
Married or living as married	19.2
Divorced, widowed, or separated	16.9
Single	23.2
Education**	
Less than high school	12.4
High school graduate	19.0
Some college	22.3
College graduate or more	18.6
Household income	
Less than \$25,000	20.9
\$25,000-\$50,000	18.5
More than \$50,000	16.0
Health status***	
Excellent	13.9
Good	18.0
Fair	28.0
Poor	34.1
Health problem****	
No	15.3
Yes	35.8
Regular doctor	
No	15.1
Yes	19.7
Insurance coverage**	
None	14.9
Private funding, outside an HMO	15.7
Private funding, enrolled in an HMO	22.0
Public funding, outside an HMO	25.6
Public funding, enrolled in an HMO	13.3

EXHIBIT 2**Use Of Second Medical Opinions (SMOs) By Persons Who Visited A Health Professional In The Past Year, 1994 (cont.)**

	Received an SMO
Perception of being treated badly***	
No	17.3%
Yes	33.2
Perception of receiving better care if different race**	
No	18.2
Yes	29.5
English as primary language	
No	15.9
Yes	19.1
Generational status (in United States)	
First	16.4
Second or beyond	18.9
Location of care****	
Admitted to hospital in past year	43.3
Used emergency room but not hospitalized	23.0
Doctor visit, but not emergency room nor hospitalized	12.3

SOURCE: Commonwealth Fund Survey of Minority Health, 1994

NOTES: Means are weighted to estimate population prevalences. *P*-values are from chi-square statistics. HMO is health maintenance organization.

** $p < .05$ **** $p < .001$

had more than twice the odds of receiving an SMO than did those without such a problem.

■ **ETHNICITY/RACE.** Subgroup analyses showed that differences by ethnicity/race existed, but they depended on one's sex and primary language, which is often a proxy for level of acculturation. For example, being female was a strong predictor of getting an SMO among Hispanics and blacks/African Americans. But the effect among these two subpopulations was in the opposite direction: Hispanic women were more likely than Hispanic men to get an SMO, whereas black/African American women were less likely than black/African American men to get an SMO. English as a primary language significantly decreased the odds of obtaining an SMO among Asian Americans/Pacific Islanders, whereas it was not related to the use of SMOs among the other subpopulations. For Hispanics, generational status was a stronger predictor: First-generation Hispanic immigrants were much less likely to get SMOs than were

Hispanics who had been in the United States for a generation or more.

DISCUSSION

Our study shows that of those persons who visited a doctor in the year prior to the survey, 18.8 percent sought an SMO (16.3 percent of all persons). As one might expect, insurance status was related to the use of SMOs. What was surprising was the variation by type of insurance plan. There was a significant discrepancy in the use of SMOs between persons with public insurance who were enrolled in an HMO (13.3 percent) and who were not in an HMO (25.6 percent). This difference could be an indication of barriers to care for HMO enrollees. If people in Medicare and Medicaid managed care plans want SMOs but are being denied access, legislation might have a positive effect. If patients choose not to get SMOs because they are uninformed about this option, or do not feel that it is culturally appropriate, then legislative efforts to provide

patient protection should take this into account.²⁰

Another curious finding was that having a regular physician was not related to obtaining an SMO. One would expect that people with a regular physician would be more likely to build a long-term, trusting relationship and that, as this relationship develops, the physician would learn the patient's preferences and cultural expectations. We would expect this relationship to be reflected in lower rates of SMOs among patients with a regular doctor. On the other hand, having a good relationship with a regular doctor could facilitate the process of obtaining an SMO. This raises the question of whether getting an SMO is related to trust and whether getting an SMO affects this trust.

■ **STUDY LIMITATIONS.** Respondents were not asked to identify the illness for which they obtained the SMO, and they were not asked if the SMO was ordered by the health plan or done on their request.²¹ Both of these would be critical data if one wanted to determine if SMOs reduce agency problems, such as undertreatment.

■ **FUTURE RESEARCH.** There are many avenues for future research. First, we need to gain a better understanding about why people get SMOs, taking cultural values and expectations into account. The differences in the use of SMOs by race/ethnicity may reflect distinct sociocultural perceptions of the patient's and physician's roles. Second, we should ask whether obtaining an SMO affects outcomes such as trust, physician satisfaction, malpractice claims, and quality of life. The relationship between trust and second opinions is probably complex and dynamic; trust is likely to govern whether the patient seeks an SMO, and the SMO is likely to affect patients' trust in their physician. If seeking an SMO facilitates trust building and improves the flow of information, then SMOs may be an *ex ante* mechanism to help patients protect themselves against improper care. As such, perhaps SMOs would reduce the use of *ex post* governance mechanisms, such as malpractice claims or defensive medicine.²²

THE MOVEMENT TO prepaid financing has changed America's perception of the health care system. Controlling costs remains an immediate goal of managed care, and consumer advocates and policymakers are still searching for ways to enhance choice, to increase trust, and to protect patients. Mandating access to second opinions is one approach. The hope is that second opinions would act as a check and balance, safeguarding the patient from being improperly treated. In our exploratory study the use of SMOs varied with health status and perceptions of being treated badly and by race/ethnicity and educational attainment. We suspect that cultural norms and sociocultural factors may determine who benefits from SMO legislation. Nevertheless, mandating access may not provide protection to all persons who are at risk of being improperly treated.

The economic cost associated with obtaining SMOs is not trivial. If a second opinion costs \$75, then at least \$3.2 billion was spent on SMOs in 1994.²³ This should be a sign to the policy and research community that we can no longer ignore this issue.

.....
Funding to Todd Wagner was provided in part by a National Institute on Aging predoctoral training grant (GK09 405940 31028), by a grant from the Agency for Health Care Policy and Research (R03 HS09997), and by the Center for Health Management Studies at the University of California, Berkeley. The authors thank Michael Schoenbaum for his comments and advice. They also thank Hattie Skubik Hanley, assistant director of health policy development in the California Department of Health Services; her comments were her own and did not reflect those of the state or the department. Two anonymous reviewers provided much appreciated advice and criticism. An earlier version of this paper was presented at the 1998 Association for Health Services Research annual meeting in Washington, D.C. Usual disclaimers apply.

NOTES

1. P.A. Lindsey and J.P. Newhouse, "The Cost and Value of Second Surgical Opinion Programs: A Critical Review of the Literature," *Journal of Health Politics, Policy and Law* 15, no. 3 (1990): 543-570.
2. P.R. Kongstvedt, *The Managed Health Care Handbook*, 3d ed. (Gaithersburg, Md.: Aspen, 1996).
3. See Lindsey and Newhouse, "The Cost and Value;" R.M. Scheffler, S.D. Sullivan, and T.H. Ko, "The Impact of Blue Cross and Blue Shield Plan Utilization Management Programs, 1980-1988," *Inquiry* 28, no. 3 (1991): 263-275; and S.N. Rosenberg et al., "Effect of Utilization Review in a Fee-for-Service Health Insurance Plan," *New England Journal of Medicine* 333, no. 20 (1995): 1326-1330.
4. A. Chu, V. Lavoie, and E.G. McCarthy, "Second Opinion Programs: Continued Savings from Nonconfirmed Surgeries," *Employee Benefits Journal* 17, no. 3 (1992): 35-40.
5. E.J. Emanuel, "Medical Ethics in the Era of Managed Care: The Need for Institutional Structures Instead of Principles for Individual Cases," *Journal of Clinical Ethics* 6, no. 4 (1995): 335-338.
6. T.E. Miller, "Managed Care Regulation: In the Laboratory of the States," *Journal of the American Medical Association* 278, no. 13 (1997): 1102-1109.
7. W.A. Magat and W.K. Viscusi, eds., *Informational Approaches to Regulation* (Cambridge, Mass.: MIT Press, 1992).
8. T. Rice, M.L. Graham, and P.D. Fox, "The Impact of Policy Standardization on the Medigap Market," *Inquiry* 34, no. 2 (1997): 106-116.
9. California A.B. 341, "Health Care Coverage: Second Opinions" (1997).
10. Florida Insurance Code, sec. 641.51.
11. Missouri S.B. 754 (signed into law in 1998).
12. Indiana Insurance Code, sec. 27.13.37.
13. Florida Insurance Code, sec. 641.51.
14. A.B. 341, "Health Care Coverage: Second Opinions." The opposition on record included Pacific Care, Blue Cross of California, the California Association of Health Plans, and the Health Insurance Association of America.
15. C.J.R. Hogue, M.A. Hargraves, and K.S. Collins, eds., *Minority Health in America: Findings and Policy Implications from the Commonwealth Fund Minority Health Survey* (Baltimore: Johns Hopkins University Press, forthcoming). No data are available on nonrespondents.
16. The multivariate model included race/ethnicity, sex, age, marital status, health status, mental health status, health problem, educational attainment, household income, regular doctor, health insurance status, perceptions of being treated badly, perceptions that care would have been better if respondent was of a different race, English as primary language, and generation status. The exact categories are listed in Exhibit 1. It was not possible to analyze the data according to which states did or did not have a legal right to a second opinion.
17. Stata Version 5.0 (College Station, Penn.: Stata Press, 1998).
18. This relationship should be interpreted cautiously because location of care may be determined by whether the person had a second opinion or not (that is, it may be endogenous). For that reason, location of care was not included in the multivariate analysis. However, further multivariate analyses indicated that among white non-Hispanics who were hospitalized ($n = 480$), sociocultural factors—including race/ethnicity, educational attainment, and perceptions of being treated badly—were significantly associated with the use of SMOs.
19. Regression results can be obtained from Todd Wagner by e-mail at twagner@odd.stanford.edu.
20. This may be just a statistical artifact indicating that people choose their insurance type based on their risk and that those enrolling in HMO plans are of lower risk. In further analyses we separated Medicare from Medicaid. Despite the small cell sizes, the direction of the effect does not change.
21. The data were cross-sectional, and some of the variables, such as enrollment in an HMO, may be endogenous. Unfortunately, the data set did not contain any variables that could serve as instruments. More general limitations of the data set are discussed in Hogue et al., eds., *Minority Health in America*.
22. A related line of research has shown that primary care physicians who interject humor, who work to educate their patients, and who actively involve the patient in the checkup have fewer malpractice claims. See W. Levinson et al., "Physician-Patient Communication: The Relationship with Malpractice Claims among Primary Care Physicians and Surgeons," *Journal of the American Medical Association* 277, no. 7 (1997): 553-559.
23. This estimate is conservative because it assumes that people only had one second opinion at a cost of \$75. The cost of \$75 is based on Medicare's reimbursement rate for a doctor's visit at the University of California, San Francisco, in 1996, deflated to 1994 dollars using the medical services component of the Consumer Price Index.